Interdepartmental Health Council of New York City

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IN NEW YORK City the responsibility for locally administered, tax-supported health and medical care service is divided among four city agencies: the departments of health, hospitals, welfare, and the community mental health board. The establishment of the Interdepartmental Health Council of the City of New York, composed of the commissioners of health, hospitals, mental health services, and welfare, was a deliberate effort by the city government to achieve a reasonable degree of coordination in the administration and development of its essential health services.

The distribution of health programs among four different departments is partially the result of the specialization that is necessary in a city of 8 million persons. In part it also reflects the routes by which State and Federal funds are channeled into the city for locally administered programs.

The rapid expansion of tax-supported health services, each with its special reimbursement and eligibility formulas, has resulted in the programs of the four city agencies becoming increasingly interlocked. This interlocking, first thrust upon the departments by the force of external events, has been intensified by design through the creation of the interdepartmental health council (IHC).

In the comprehensive study of city government by the Mayor's Committee on Management Survey, 1950–52, special studies made of the health department and the hospitals department were the subject of a community health conference. The conferees suggested, and the surveyors of the health department concurred, that:

> The Mayor of the City of New York should designate in the four or five critical departments touching upon the field of health either the Commissioner or his appropriate representative to be members of what might be called an interdepartmental conference, these departments being Health, Hospitals, Welfare, Education and Correction. Those departments have many problems which touch upon each other, very immediate problems, which are worthy of prompt consideration.
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> In any structure so elaborate as that of the government of the City of New York, so necessarily specialized, it seems desirable to at least provide some official structure so that he (the Mayor) may call for or topics may be assigned to such a conference with representatives of these five departments (*1*).

In November 1952, Mayor Vincent Impellitteri implemented this recommendation by establishing the Interdepartmental Health Council of the City of New York to "provide maximum coordination of the health services for the people of this city, to solve problems of overlapping jurisdiction and matters of policy, and to make recommendations and studies on the health needs of the city."

Initially the interdepartmental health council consisted of the commissioners of health, hospitals, and welfare. The Community Mental Health Board of New York City was created in 1954, and its director (later, commissioner of mental health services) was added to the council's membership in August 1955.

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All the functional areas recommended for representation in the council are included in its present four-commissioner membership. The New York City school health service and the medical services of the department of correction are administered by the department of health. Psychiatric services in the schools, courts, and correctional institutions are supported by the community mental health board.

The first meeting of the council, held on November 24, 1952, was attended by the commissioner of hospitals (who was designated as the first council chairman), the commissioner of health, and the commissioner of welfare. The first problem proposed for interdepartmental consideration was the care of nonhospitalized persons with active tuberculosis. Other problems noted then were those of the aging, Puerto Rican affairs, child health, and poor housing. A subcommittee on agenda was appointed to screen material for the council. It later was renamed the steering committee and was composed of two persons at a policymaking level representing each of the IHC departments.

Council Policies and Structure

At a meeting of the interdepartmental health council and its steering committee on December 10, 1952, four basic operating policies were adopted:

1. The council is an interdepartmental agency without veto power over any action or decision taken by any commissioner which affects his own department.
2. The council need not be tripartite, that is, it may deal with matters and problems relating only to two of the three departments.
3. The council chairman alone is empowered to speak for the council for publication.
4. While on occasion the opinion of civic organizations might be requested, the council should avoid holding public hearings on matters before it as much as possible.

These operating policies still hold with slight modification. The council does not have veto power over any commissioner and cannot mandate action by any commissioner. "Speaking for the council," however, is no longer the sole prerogative of its chairman. The chairman or any other member of the interdepartmental health council may make a public statement of policy, but such a statement is always cleared in advance with all IHC commissioners. By executive order of the mayor, statements to legislative bodies must have prior clearance with his legislative representative to assure consistency of policy statements.

The council meets monthly to consider problems of concern to two or more departments and to act on recommendations submitted by its committees. The meetings are conducted informally, often over sandwich luncheons in the chairman's office. Ordinarily only the commissioners, the steering committee chairman, and the executive secretary attend the meetings; however, others may be invited to present special agenda items.

An agenda with supporting material is distributed in advance, but new business growing out of the immediate concerns of the commissioners may be taken up and, in fact, may take precedence over the regular agenda. Agreements reached and policy positions taken are recorded in officially approved minutes. A commissioner absent from a meeting, an infrequent occurrence, is consulted about the proposed action before its official adoption.

Chairmanship of the council is rotated each calendar year in a sequence ordered by the office. Thus, the commissioner of welfare was chairman in 1963; the commissioner of mental health services, in 1964; the commissioner of hospitals, in 1965. The commissioner of health is the IHC chairman for 1966.

The simplicity and flexibility of its organizational structure undoubtedly have contributed to the success of the council. It is neither a supra-agency nor an operating agency. Its professional staff consists of an executive secretary, administratively located in the health department, where she reports to the deputy commissioner for program planning, research, and evaluation. The department of hospitals provides secretarial staff. The council does not have its own budget.

The steering committee includes, in addition to the two persons at deputy commissioner or assistant commissioner level named from each of the IHC departments by their respective commissioners, the chairmen of standing sub-

committees and a representative of the office of city administrator, who serves in a liaison capacity. The steering committee's functions are to: (*a*) receive and act on matters referred by the council, (*b*) monitor standing or special subcommittees, and (c) bring to the council's attention matters which require planning and action, including specific recommendations based on prior study by subcommittees and also on new issues which the steering committee believes merit attention.

The council looks to its steering committee, with its resources and knowledge of field operations, to identify major issues and alert the commissioners to the need for study and action. (IHC minutes, December 17, 1963).

Directly responsible to the steering committee are four or five standing subcommittees authorized annually for a calendar year and also ad hoc committees which are task and time limited. The subcommittees work at problem solving within a broad area of service. Subcommittees on the aged, addiction, maternal care, rehabilitation, and tuberculosis functioned in 1965.

A subcommittee, the steering committee, or the IHC may identify problems, or they may be referred by another city department or a voluntary organization. When the problem is administrative and the solution within the authority of the committee members, corrective action may be taken without reference to the council. When policy is involved, the committee recommendation is submitted to the council.

The council appoints the chairmen of the steering committee and its subcommittees. An effort is made to maintain reasonable distribution of offices among the departments and periodically to rotate them; however, these criteria are applied flexibly. The primary consideration is the relevance of the committee assignment to the chairman's professional activity.

Committee membership is drawn from the staff of the four departments, and the commissioner of each department makes the appointments. Representatives of other city departments or of voluntary agencies who are not regular members of subcommittees may be invited to meet with subcommittees as needed.

An important byproduct of IHC committee work is the opportunity it gives members of one department to become acquainted with colleagues in other departments. The council's letter transmitting its second annual report to the mayor comments:

> Probably as important as the specific accomplishments . . . is the growing cooperation on a day-to-day basis among individual members and divisions of our departments. The lines of communication are more direct; there is less red tape; there is more knowledge about the operations of other departments which is used in solving interdepartmental problems. Health and welfare problems are, after all, interdependent. There is no question but that the existence of the interdepartmental health council has helped each department's work enormously (*2*).

The statement that health and welfare problems are interdependent was expanded a few years later into the principle that public health and public welfare have a joint responsibility for the quality of welfare medical care and the arrangements for its delivery. In October 1958, the council with the wholehearted concurrence of the commissioner of welfare appointed a task force to "conduct a study of needs of welfare clients for medical care and how these needs may best be met" (IHC minutes, October 28, 1958).

The task force was headed by Dr. George James, deputy commissioner of health, who later was loaned temporarily to the welfare department to administer its medical program. In May 1959, the council acted on the task force report and unanimously agreed to "seek approval for a top level, medical position in the department of health budget for an administrator of medical welfare services who will carry, on a permanent basis, the responsibilities now carried on a temporary basis by the deputy commissioner of health" (IHC minutes, May 15, 1959).

In August 1960, Dr. Alonzo S. Yerby was appointed to the position of executive director for medical care services by the commissioner of health and was simultaneously appointed medical welfare administrator by the commissioner of welfare. The position was placed at the deputy commissioner level in both departments with executive staff responsibilities in each department.

After the first year of operation the commissioners of health and welfare commented that

"those who decided on this joint venture did so in the hope that it would be possible to bring to bear on welfare medical care arrangements—which in New York City as elsewhere have grown up outside the public health agencies—the professional competence and skill which the public health profession has demonstrated in the organization of other health agencies for the population" (*3*).

The commissioners also reported on special projects designed to improve the quality of medical care for welfare recipient patients and on plans made for the more advantageous use of interdepartmental health resources (*4, 5*). The interdepartmental relationship was further solidified in 1964 when the commissioner of hospitals appointed Yerby coordinator of welfare services for the hospitals department to facilitate his freedom of movement within this department in developing and carrying out medical care arrangements for welfare patients.

The pattern of interlocking professional responsibility, endorsed by the council, has been used effectively by the community mental health board in extending mental health consultation service to various city departments. Directors of psychiatry are employed by the community mental health board and collectively function as a professional cabinet to the commissioner of mental health services. By agreement of the respective commissioners to whom they are administratively responsible, they individually serve as psychiatric consultants in the departments of correction, health, hospitals, welfare, and with the courts.

Cooperative Ventures

Another firm IHC policy is that setting of standards is a mutual responsibility of the council's departments. For many years, the department of health has been involved in setting standards for the handicapped children's program and the maternity and newborn program. The first application of the principle by collective action through the council was in the care of amputees (*6*).

Clinical dissatisfaction with prostheses for amputees purchased under a city contract and other inadequacies, notably frequent lack of comprehensive evaluation and treatment of these handicapped persons, were reported by the rehabilitation subcommittee. The council therefore appointed an advisory committee to develop standards for the care of amputees. The committee had an almost entirely nongovernmental membership of leaders within the medical profession.

After the council adopted the standards for care of the amputees and the hospitals were surveyed, the advisory committee recommended 15 hospitals for approval. The IHC designated these hospitals as having "an approved amputee service." The voluntary and municipal hospitals were then notified that after January 1, 1962, all amputees whose care was paid for by the departments of health, hospitals, or welfare and who could be expected to benefit from being fitted with prostheses and from rehabilitation and training were to be referred to these approved services. Furthermore, from that date only the approved services were authorized to order prostheses for a city-charge amputee patient (*7*).

A panel of approved dealers was established consisting of those qualifying for membership in their professional association and who agreed to a negotiated price scale. Under the new procedures executed simultaneously in the three departments, the approved amputee services are permitted to order prostheses from the dealer of choice on the panel. These procedures have resulted in improved quality and more rapid delivery of prosthetic devices. Most important, the procedure provides leverage in implementing a policy of referrals to approved amputee services.

A similar approach is being followed by the interdepartmental health council in other areas of medical care. Standards for neurosurgical centers and services and criteria for payment to hospitals caring for patients with cancer have been developed by special advisory committees and adopted by the IHC. Standards for thoracic and cardiac surgery are in the process of development.

The former council chairman, Dr. Ray E. Trussell, recently stated, "What is often overlooked is that when public agencies insist on standards in hospitals before expending public funds for the care of patients who are a public responsibility, the paying patients also benefit as a byproduct" (*8*).

The Queensbridge project described elsewhere in this issue is an excellent example of cooperative enterprise undertaken by the council and another city agency, the New York City Housing Authority. When the four commissioners agree to such a joint project, it is necessary to assign primary operating responsibility to one department and decide the roles of the other departments. For the Queensbridge project, the health department assumed administrative and major budgetary responsibility, the housing authority provided space, and the other three departments made significant contributions to the program.

An even more ambitious cooperative venture is underway. The council, with the full endorsement of the city administration, is committed to offering integrated community health and medical care services to the Lower East Side neighborhood. Services are to be based in and emanate from the new Gouverneur hospital-health facility which is under construction. Here, services traditionally offered by the four council departments in separate locations will be provided as an integrated package under a contract affiliation with the Beth Israel Medical Center.

The scope of services planned includes in-hospital, outpatient, and home care; definitive treatment and preventive services; health maintenance, psychiatric day care, and day-center activities for the elderly. Fortunately, Beth Israel shares the council's enthusiasm for tackling the challenging and admittedly difficult task.

As Trussell has pointed out, it will be necessary to "blur" department lines to provide integrated services. He noted: "Thus, hospital clinics are being operated in health centers, and several new 'hospitals' which are being built or designed by the city are actually multipurpose facilities designed to deliver services of the departments of health, hospitals, welfare, and the community mental health board, all tied by affiliation contracts at city expense with strong voluntary teaching hospitals and medical schools" (7).

The goal is to package the health care services so that first consideration is given to family health and social needs, not to family eligibility for service on a department-by-department basis. The experience gained in the IHC-initiated, combined health-hospital chest clinics, in the Queensbridge health maintenance project, and in the recently developed satellite maternal care clinics suggests some models that may be used in interdepartmental programs for Gouverneur and other multipurpose facilities to be constructed in the future.

Another function the interdepartmental health council performs periodically is to develop position statements on health legislation, most frequently by presenting testimony at public hearings held by State legislative committees. The council may also advise the mayor, at his request or on the council's initiative, of the position the IHC recommends that the city take on specific State or Federal legislation.

The council has appeared at three hearings on New York State's program of Medical Assistance for the Aged (MAA) to testify on proposed changes in legislation. It has been the city's spokesman several times at legislative committee hearings on alcoholism, narcotics addiction, and admission of patients to State mental hospitals. The commissioner whose department is most closely related to the subject matter of the hearing ordinarily assumes responsibility for drafting and clearing the testimony. He or a designated staff member appears before the committee as the IHC's spokesman.

From the author's perspective of 9 years of service with the interdepartmental health council, the evidence of its accomplishments is impressive. The IHC is a mechanism without a statutory base whose effectiveness, therefore, must derive from the esteem in which it is held by its members and the city administration.

Summary

The Interdepartmental Health Council of the City of New York is the mechanism that the commissioners of health, hospitals, mental health services, and welfare use to coordinate the city's health and medical services. Through regular meetings of the commissioners, interdepartmental staff committees, professional advisory committees, and interlocking directorates between departments, the council upgrades the quality of medical and health care,

sets standards, and resolves administrative problems. Brief descriptions of the city's cooperative ventures in welfare medical care and of an amputee service program, a health maintenance service for the elderly, a multipurpose hospital-health facility and program, and legislative activity illustrate the council's methods of operation.

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Early Slum Lords

In 1865 when Dr. Stephen Smith was arguing before a committee of the New York State Legislature for passage of a metropolitan health bill, he recalled the deadly typhus epidemic in New York City in the 1850's. Smith, after his internship at Bellevue Hospital, was placed in charge of tents on Blackwell's Island where the overflow typhus patients were treated.

Noticing that patients were continually admitted from a single building, he visited the "fever nest," finding the house in complete dilapidation. "Doors and windows were broken, the cellar partly filled with filthy sewage, the floors littered with decomposing straw used for bedding; every available place from cellar to garret was crowded with immigrants—the atmosphere was heavy with the sickening odor of the deadly typhus." The need to close the house, at least temporarily until it could be cleaned, was imperative.

When located, the agent for the house said the owner had given instructions that his name not be revealed. Visiting the police department, Smith found there was no law under which the police could take action. Tax lists revealed the owner, a wealthy man living in an exclusive neighborhood, who refused to remedy the infested tenement.

When Smith told the story to William Cullen Bryant, managing editor of the "New York Evening Post," Bryant promised to send a reporter to make notes of the hearing if the police would arrest the delinquent owner. The landlord, after learning the Post intended to publish the court proceedings, took steps to improve the house which became one of the cleanest tenements in the district.—*Excerpted from "The City That Was" by Stephen Smith, Frank Allaben, New York, 1911.*